



# COMBINATION BENZOYL PEROXIDE & CLINDAMYCIN AGENTS



New Hampshire

## NH Medicaid Prior Authorization Request Form

**Fax: 1-888-603-7696    Phone: 1-866-675-7755**

Date of Medication Request: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Section I: Patient Information and Medication Requested:

Name: (Last, First) _____	NH Medicaid Number: _____
Date of Birth: ____ / ____ / ____	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female
Drug Name: _____	Strength: _____
Dosing Directions: _____	Length of Therapy: _____

### Section II: Clinical History:

1. Has the patient failed a trial or past therapy with a single topical retinoid or benzoyl peroxide medication?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If YES, please list treatment failures and provide dates:		
_____		
_____		
_____		
_____		
Please provide any additional information that would help in the decision-making process. If additional space is needed, please use a separate sheet.		
_____		
_____		
_____		

### Section III: Prescriber Information:

Print Name: _____	DEA Number: _____
	NPI Number: _____
Phone Number: (____) _____ - _____	Fax Number: (____) _____ - _____
I certify that the information provided is accurate and complete to the best of my knowledge and I understand that any falsification, omission, or concealment of material fact may subject me to civil or criminal liability.	
_____ Signature of Prescribing Provider	